STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155327	A. BUILDING _____ B. WING _____	C 03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY	**1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00165599, IN00167829 and IN00168144.

Complaint IN00165599 - Substantiated, no deficiencies related to the allegations are cited.

Complaint IN00167829 - Substantiated, no deficiencies related to the allegations are cited.

Complaint IN00168144 - Substantiated, no deficiencies related to the allegations are cited.

Survey dates:
March 2, 3 and 4, 2015

Facility number: 000220
Provider number: 155327
AIM number: 100267650

Survey team:
Diana Zgonc, RN-TC

Census bed type:
SNF: 35
SNF/NF: 114
Total: 149

Census payor type:
Medicare: 23
Medicaid: 96
Other: 30
Total: 149

Sample: 7

University Heights Health and Living Community was found to be in compliance with 42 CFR Part

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155327	A. BUILDING _____ B. WING _____	C 03/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSITY HEIGHTS HEALTH AND LIVING COMMUNITY	**1380 E COUNTY LINE RD S INDIANAPOLIS, IN 46227**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00165599, IN00167829 and IN00168144. Quality Review 03/05/15 by Lisa McColly	F 000		